MODERN MEDICINE AND THE HEALING PROCESS

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Modern medicine has made significant and tangible advances in curing disease. However, its overly "scientific" and technological emphasis has neglected the soul and the healing bond between patient and physician. This paper examines the human experience of medicine through clinical examples, historical antecedents, and the etymological differences between curing and healing. It underscores the need for physicians to heal themselves and to renew their respect for the art and the intangibles of faith, hope, and compassion as well as the science of medicine. Finally, this paper emphasizes that if medicine is to remain a healing profession, it must pay more attention to the soul and to the healing process in medical education, research, and practice.

The close-up, reassuring, warm touch of the physician, the comfort and concern ... are disappearing from the practice of medicine, and this may be too great a loss for the doctor as well as for the patient. If I were a medical student or an intern, just getting ready to begin, I would be more worried about this aspect of my future than anything else. I would be apprehensive that my real job, caring for sick people, might soon be taken away, leaving me with the quite different occupation of looking after machines. I would be trying to figure out ways to keep this from happening" (1).

In Western medicine today, as suggested in the ancient Chinese character for crisis, there is both danger and opportunity. A critical question cries out for an answer: Will medicine remain a healing profession? We have made major technological advances and, in the process, have made immense progress in understanding and combating disease. However, modern medicine seems to have lost sight of the art, the spirit, and the intangibles such as faith, hope, and compassion that are essential to the healing process (2).

THE ART OF HEALING (WITH CLINICAL VIGNETTES): Tumulty stresses the necessity for healing of the imponderable spiritual components, including hope, faith, compassion, and empathy (3). Frank (4) points out that the most powerful healing emotion is "expectant faith". Eighty years ago, Osler (5) admonished physicians to "mix the waters of science with the oil of faith."

Healing is the product of a human bond between patient and physician. The doctor/patient partnership is increasingly important to the healing process (2; 6–9). Before he enters his patient’s room, Stephen Ray, a plastic surgeon, meditates (2, p. 23). He lets go of everything on his mind and goes in with full receptivity — to accept the patient completely. He says, "I go in with love. I embrace the patient and his or her pain and problem. I take it all in: it's on a spiritual level. I get as close as I can to the patient. I listen and try my best to walk in the patient’s shoes: to experience his or her illness and understand the patient as best I can." He views all patients as valuable human beings and tries to help them find meaning in their illness and suffering. Cassell underscored this attitude in his paper "The nature of suffering and the goals of medicine" (10). In a seminar on healing, Ray showed videotapes of several of his patients and his interaction with them. Of one patient who was disfigured from congenital abnormalities of the facial bones, he said, "I embrace this person

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without judgment like I'd embrace a gnarled and twisted tree as part of God's creation." Another of his patients, an attractive model who had sustained extensive disfiguring injuries, described her reaction when she again looked in a mirror: "I looked like a poor refugee child, hungry and haunted, worse than death." She felt extremely depressed, ashamed, and "alone." She knew that, by being there and listening, Dr. Ray helped her immensely. She summed it up: "People who love, listen."

To illustrate the modern loss of empathy, I would like to share several vignettes from my teaching and clinical experience.

Mrs. T.
The medical and nursing staff stood by helplessly while this woman became paraplegic, her body ravaged with cancer. Beginning in her lungs, the cancer had spread to other parts of her body. Recently it had invaded her spine and caused weakness in her legs and severe back pain. When admitted to the hospital, she had great difficulty walking unaided. Although the staff obtained many X-rays and did many tests, they concluded that nothing could be done to reverse the process.

I met Mrs. T. when one of her doctors requested a psychiatric consultation. We asked two questions: "What is Mrs. T.'s problem?" and "How can we help?" The resident replied, "She's depressed. She can't accept the fact that she'll never walk again, and that nothing can be done to cure her. In addition, she needs someone to talk to." Immediately, I wondered why this young doctor couldn't talk with his own patient; what got in the way of his accepting her, listening to her, and establishing a healing partnership with her? Was the resident upset and frightened? Was he overworked? Did he feel helpless and impotent because he could do nothing - that is, offer no cure?

Modern medicine has neglected the soul and the healing bond between patient and physician.

We went in to meet Mrs. T. Her initial concern was, "Am I crazy?" We assured her that she was not and then explained our roles. We said her doctor had asked us to talk with her about her condition and to discuss any problems she had. After a long pause she asked, "Why do I wake up crying in the night?" She had much to cry about: her spreading cancer, her back pain, and losing the function of her legs. She replied that God had told her that one day she would walk again. She was a religious person and kept a Bible and other spiritual books on her bedstand. The patient felt she was a burden; her family would have to take care of her. However, she added that they were happy and willing to do it because they loved her. Their love for her battled with her love for them: she felt uncomfortable because she had always given to them and taken care of them. Now she was having trouble accepting their love and desire to care for her. In response I paraphrased a verse from the Bible: "Whatever one soweth, that shall one also reap." Her smile and sense of peace showed that she understood my intention. She began to perceive that she no longer needed to feel like a burden.

After the initial interview, we told the patient's doctor what the patient had said and how we responded. Most likely he saw that he could have done what he called on us to do: accept the patient, listen to her, and be empathic. We discussed the helpless feeling of not being able to offer a cure to someone who is ill. We emphasized how difficult it is to take care of someone who is not going to recover. We acknowledged that it was appropriate for him to ask us to see the patient. We agreed to follow Mrs. T. with him until her discharge from the hospital. In subsequent interviews, Mrs. T. said she thought about dying and was not afraid. We understood that her assurance from God that she would walk again meant (to her) that she would walk in heaven.

What does it mean for modern medicine when other physicians ask psychiatrists to talk with and listen to their patients? Doctors who feel helpless because they cannot cure their patients often have a narrow biomedical approach toward "curing" disease. When a cure is not possible, they call in psychiatrists to deal with feelings: their patients' and their own. They use terms of pathology to describe their patients' emotions. For example, they described Mrs. T. as depressed, as denying her illness, and as delusional (her assertion that she would walk again).
Mrs. Z.
Recently this young, attractive, intelligent black woman in her twenties separated from her abusive alcoholic husband. She had two young daughters and was living with her mother. Mrs. Z. had an extremely malignant form of leukemia and had completed one course of chemotherapy. A medical student asked me to see her as part of a “psychiatric aspects of medicine” course (11); he was concerned about her feelings and welfare. Because Mrs. Z. had refused the second course of chemotherapy, the medical team was forcing her to sign herself out “against medical advice.” The student believed this move was unnecessary and punitive. Mrs. Z. wanted to live long enough, about three weeks, to complete divorce proceedings and thus make sure that her daughters would be safely in her mother’s custody. As I talked with the patient, I learned that she was ready to die. She believed God wanted children and beautiful young people in heaven so that there wouldn’t be only the old and debilitated there. When a student asked her if she was afraid to die, she said “No,” then looked into his eyes and said “What about you? Are you afraid to die? You know you could leave the hospital today and be hit by a car.” Later this student said this encounter was one of the most important moments in his medical clerkship.

The health-care system, instead of meeting Mrs. Z.’s wishes and sending her home with advice, support, compassion, and follow-up care, punished her for exercising her right to refuse a treatment that offered no hope of a cure. She was not helped as a person to feel whole. As Hegel pointed out, you become what you fight; modern medicine fights disease and death and, as a result, has become diseased and dead – the soul is missing. As Paul Tournier has suggested, “To treat the patient rather than the disease means helping our patients resolve their personal problems and aiding inner transformation – on a spiritual level” (12).

Ms. M.
This health professional, an immigrant from Europe, had suffered from long-standing, severe, and crippling depression. She had been orphaned and had no known family. When I first met Ms. M., she had just made her third serious suicide attempt. She had not responded to two courses of electroconvulsive therapy (ECT) or to several high-dose trials of antidepressants, including tricyclics and MAO inhibitors. Ms. M. was in individual psychotherapy and in a group for suicide attempters. This supportive group seemed to provide an extended family for this extremely despondent and alienated person. Her value system was inverted; death was at the top. She was obsessed with death and with ending her own life. Ms. M. lived alone on the twenty-third floor of a highrise apartment building. Often she called me and other group members threatening to jump off the balcony. Her condition worsened and I thought she might end her life at any time. We tried without success to get her admitted to a university-based psychiatric inpatient service. Finally, on their own initiative, her support group rented a truck and moved her out of the lonely, dangerous highrise and into a ground-floor room in a residence club. Within a month she seemed less depressed; she had met an older man, “the Professor,” who lived at the club. This relationship developed to the point where she lost her chronic depressive symptoms and her obsession with suicide and developed positive emotions and a zest for life.

HISTORICAL ANTECEDENTS: Galen (13), the primary post-Hippocratic figure in medicine, attempted to reintegrate the body and soul into a meaningful whole. His approach blended philosophy and medicine and his influence lasted through the Renaissance. Neo-Galenic Renaissance physicians, viewing the body (soma) and soul (psyche) as inseparable, posited three intermediary spirits – animal, vital, and natural – and believed that the soul was the ultimate source of all physiological functions. Francis Bacon removed the soul and human behavior from the purview of science (14). The Baconian model laid the bedrock for the body/soul split in modern medicine. Descartes, in his classic Treatise of Man (15), viewed the body as a machine. He viewed the soul as an entity separate from the body but resident in the pineal gland. He maintained that the soul was “rational” and gave it a consciously cognitive role. Descartes repudiated Plato’s concept of an “irrational” soul and denied the concept of the soul or psyche as a life force. He rejected the concept of vital or natural spirits but retained the concept of animal spirits, to which he assigned a variety of roles in the brain and nerves (for example, motor transmission).

In psychiatry, Freud’s brilliant discoveries opened the
door to the psyche and its relationship not only to psychological but to somatic disturbances. Nevertheless, he saw no need for “the soul, the spiritual part of man.” After dismissing the soul as an illusion, he then elevated “Logos” (reason) to the status of “God” (16). However, some segments of the Freudian analytic community, exemplified by Searles (17) and Kohut (18), have evolved more feeling-based and empathic techniques to balance Freud’s excessively rational emphasis. Kohut (18) warns that rigidly held scientific systems stifle “playful creativeness” and “impede the activities of the sector of the human spirit that points most meaningfully into the future.” Searles (17) and Groesbeck (19), like Jung (20) before them, are willing to be open to the patient’s sickness and to feel the patient’s pain, to suffer with the ill individual and to involve themselves in the healing process. Physician psychanalysts must know and participate in their own “incurable wounds,” as did Aesculapius and Chiron in the ancient legends.

In his book The Wounded Healer, Nouwen (21) described the healing process: “No one can help anyone without becoming involved, without entering with his (or her) whole person into the painful situation, without taking the risk of becoming hurt, wounded, or even destroyed in the process.” Hillman (22) emphasizes the same point: “It is of no help to patients to share one’s problems. If you’ve got the same problems as you do.” Healing emerges from the wound’s depth and leaves a scar. The scar is the mark that we’ve entered wounded consciousness. ... Our woundedness is hidden understanding and grounding support.”

**Healing is a process that is closely related to the word “holy.” The issue of the soul must be addressed; it is central to the healing process.**

The shamanistic cultures found in primitive societies represent another example of the “wounded healer.” Shamans believe they are “called” and enter their ministry of healing under an inner compulsion. American Indian healing rests on shamanic ideas. Navajo sand painters, for instance, reconstruct the harmony of the universe in their sand paintings and seek to restore patients to health by making them part of the essential harmony and wholeness of all life, which the sand paintings express (23). Patients sit inside the mandalic paintings, which constellate the negative energy of the evil spirits, and this, along with chants and prayers, becomes a critical part of the patients’ experience of the healing process.

Drawing and painting have been central in my own healing process (24). Whenever I become depressed, I draw or paint; this activity invariably helps resolve my melancholic state. A poet friend gave me a book entitled *Shamanism: The Beginnings of Art* in which I found that “again and again the shaman had to free himself from a deep depression by a creative act” (25).

**Healing through Art and Self-Knowledge:** John Stone, the cardiologist/poet, believes that art has a wonderful capacity to heal. He writes poetry because it gives him knowledge and understanding of himself and life. Osler believed that medical proficiency must be balanced with knowledge of oneself lest the physician fail in his or her healing endeavors (5). Stone (26) raises the same issue. “I wonder how seriously we have considered the probability that art may actually help the physician in his or her progress toward healing.” He admonishes physicians to create something and adds, “I believe that literature, music, painting, or sculpture can and do make a subtle but important difference at the bedside.”

A poem of Stone’s, “He Makes a House Call,” from his book *In All This Rain* (27) amplifies what he means. I recommend it warmly to anyone interested in humane care. Music, like poetry, is another healing art. Stone says, “It is, in my judgment, not too much to say that the music of Mozart may well be responsible for the prevention of more mental illness than we know or give it credit for” (26). Pellegrino also cites music’s healing qualities: “Many things are said to have been accomplished for ill men through the use of this art, as is said of David who cleansed Saul of an unclean spirit through the art of melody. The physician Asclepiades also restored a certain insane man to his pristine health through music” (28). Plato commented on the powerful healing connection between music and the spirit: “Musical training is more potent than any other because rhythm and harmony find their way into the inward places of the soul.”

Freud could not give himself over to the experience of pure music (18, pp. 294–295). Kohut attributes this to Freud’s “need for steadfast predominance of rationality.” Logos (rationality) is a masculine principle that is opposite to the feminine principle of Eros (relatedness and nature), an essential ingredient of the healing process. Sanford (23) says that “without the feminine powers of warmth, concern and intuitive understanding, the healing process will not work. Most important, the soul
herself, which is always feminine, must be present if healing is to occur.”

Healing is also connected with humor and the ability to laugh at oneself. Stone (26) believes that the “complete physician” knows when to laugh, saying, “For all I know, in this world, it may even help to be a little bit crazy.” Greenon speaks about the need for a good personal life and the necessity to “stop being rational, analytical and correct and to be able to be irrational, foolish and wrong for a change” (29). He says we need the freedom to be carefree and to be able to play, to stimulate life forces and to aid in making contact with our own personal creative center.

To pursue our own healing, we must develop the ability to let go of old patterns, to be open and receptive, to risk the emotionally painful process of change, and to realize that, just as nightly dreams regenerate the psyche, fulfilling daydreams and carrying out creative ideas and avocational pursuits can produce meaningful changes in personality and ways of living (24).

**Healing as Relationship:** Physicians need to listen to and understand their patients or risk reducing their potential for healing in the professional relationship. Physicians can gain a fresh conception of their relationships with patients through a comprehensive human approach, such as the biopsychosocial model (30). Basic to this model and to the practice of medicine as a human experience are three qualities: acceptance, empathy, and competence (2, pp. 21–42).

Acceptance, which is rooted in biology, involves taking in, receiving through observing, listening, and feeling. Empathy (understanding and sharing in a patient’s feelings), acceptance, and biomedical (biotechnical) and psychosocial as well as humanistic competence are all inherent parts of humane medicine.

Alex Comfort believes we have been training “scientoid” doctors, technically competent as “body mechanics” but lacking self-knowledge and the human skills required for relating to patients in an empathic manner (31). He advocates that medical students be educated as “naturalist healers,” aware of their patients’ feelings as well as their own, professionals who see their patients as ecosystems within a larger ecosystem of which both physician and patient are a part.

Rosemary Gordon (32) tells us that “to cure,” from the Latin word curare, means to take care of, to take charge of, and denotes “successful medical treatment.” On the other hand, “to heal,” from the ancient English word haelen, means to make or become whole, to recover from sickness, and to get well. Healing is a process that is closely related to the word “holy”: both “healing” and “holy” derive from a root meaning “wholeness.” Gordon says, “In our work with patients we hope that both curing and healing take place. Often in psychiatry, curing the presenting symptoms and strengthening the ego in the service of integration and adaptation then allows for the center of the psyche, the Self or soul, to emerge ... facilitating the process of healing — that is, the evolution toward greater wholeness, a process in which the subject takes a particularly active part.”

George Engel has challenged modern medicine to expand its technological, disease-focused biomedical model to a more illness-oriented, patient-centered biopsychosocial model (30). He does not go far enough. The issue of the soul must be addressed because it is central to the healing process. By the soul, I mean that enlightening spirit or life-giving force which gives rise to those stabilizing, integrating powers that make a being whole and a person fully human. Such persons can find meaning and purpose in life and can feel optimism, sensitivity, receptivity, empathy and creativity. The soul is the seat of one’s emotional and moral nature — of one’s feelings and love (Eros) — in contrast to mind and intellect, which are the seat of thinking and reason (Logos). As Eric Cassell has pointed out, when physicians ignore “the human spirit” and the meaning of illness, they contribute, albeit often inadvertently, to the patient’s suffering and their own (10).

An ancient precept teaches that “heal[ing] thyself” is essential for the healing of others. The most effective healers, the “wounded” healers, are aware of their own wounds and know that they are involved in a lifelong process. In other words, one is never completely healed. To be always in pursuit of self-healing and in contact with the soul — this is the individuation process, a journey toward wholeness (33). True healing is in tune with the intrinsic healing qualities of nature. The Self represents an inner healing force that has the potential for growth, creativity, and wholeness (18; 33–35).

**Summing Up:** Healing, a natural process toward wholeness, involves the soul and the search for and finding of meaning in suffering (36). It involves letting go of ego and transcending its concerns; in other words, a death/rebirth experience (37). This process, which is facilitated by trust, empathy, and compassion, is impossible unless we as individuals acknowledge our own wounds and become involved in self-healing. Hence, the Biblical adage “Physician, heal thyself.” As Karl Menninger says, “Healing is more than repairing, more than not destroying, it is creating. It is an article of faith with us, and one without which we doctors cannot work or live, to believe that things can be improved, that the patient can be helped, and that we ourselves can always be better than we are. We must improve ourselves to improve those who seek our help. This aspiration is in itself creative” (38).
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As I conclude this paper, I discern the need to weave the pieces of the body of medicine together with the psyche into one beautiful and majestic fabric. The warp or ground is the necessary science — the scientific tangibles of biology and human behavior (the biopsychosocial model). The weft is the art and soul — the intangibles of faith, hope, love, and meaning. The creative task is to weave the tangibles together with the intangibles into a healing tapestry. If medicine is to remain a healing profession, it must pay more attention to the healing process in medical education, research, and practice. Thereby, it may find its soul.

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REFERENCES